

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33296

State File No.

8454

Registrar's No.

FILED SEP 25 1952

BIRTH NO. 105097

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Firmen Desloge Hospital		d. STREET ADDRESS (If rural, give location) 17 3965 Cleveland	
3. NAME OF DECEASED (Type or Print) Baby Cynthia - Paparic		4. DATE OF DEATH (Month) (Day) (Year) 9 - 7 - 52	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married		8. DATE OF BIRTH 9-7-52	
9. AGE (In years last birthday) -		10. UNDER 1 YEAR -	
11. UNDER 1 YEAR -		12. UNDER 1 YEAR -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Robert Michael Paparic		13b. MOTHER'S MAIDEN NAME Caroline Josephine Ritter	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Robert M. Paparic	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) * This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) anencephalic monster ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 750x		22. I hereby certify that I attended the deceased from 9-7-1952 to 9-7-1952 that I last saw the deceased alive on 9-7-1952 and that death occurred at 8:30 p.m., from the causes and on the date stated above.	
23a. SIGNATURE Patricia Brennan M.D.		23b. ADDRESS Desloge Hospital	
23c. DATE SIGNED 9-7-52		24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
24b. DATE SEP 9-52		24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	
24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO		25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schur	
DATE REC'D BY LOCAL REG. SEP 8 1952		26. REGISTRAR'S SIGNATURE J. C. Smith	
27. (Licensed Embalmer's Statement on Reverse Side)		28. (Licensed Embalmer's Statement on Reverse Side)	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Student Embalmer No. _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.